STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING 00 B. WING	12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00120199. Complaint IN00120199-Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F314 and F514. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00116313 and IN00117473 completed on October 9, 2012. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00117692 and IN00118202 completed on October 23, 2012. Survey dates: December 12, 13, & 14, 2012 Facility number: 010739 Provider number: 155764 AIM number: 200856890 Survey team: Janet Adams, RN Census Bed Type: SNF: 41	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	SNF/NF: 8 Residential: 58 Total: 107 Census payor type: Medicare: 38 Medicaid: 5 Other: 64 Total: 107 Sample: 8 Residential Sample: 3 These deficiencies reflect state finding cited in accordance with 410 IAC 16.2. Quality review completed 12/20/12 Cathy Emswiller RN			

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F0282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow the resident's plan of care related to the implementation of pressure relieving devices for 2 of 4 residents reviewed for pressure ulcers in the sample of 8. This resulted in the development of an unstageable pressure ulcer and a Stage III pressure ulcer. (Residents #B and #C) Findings include: 1. On 12/13/13 at 8:55 a.m., Resident #B was observed sitting in a wheel chair the unit Dining Room. The resident had blue Multipodus boots on both of her feet. The record for Resident #B was reviewed on 12/12/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, sickle cell anemia, brain tumor, arthritis, congestive heart failure, deep vein thrombosis, diabetes mellitus, and multiple myeloma. The resident was originally admitted to the facility in 2010 and was last readmitted on 10/18/12. Review of the 10/18/12 Nursing	F0282	F282 1. Resident B was place on a pressure relieving mattress on 11/12/12. Resident C was discharged on 10/29/12. 2. All residents Care plans were updated on 12/28/12 for resident with specific approaches related pressure relieving devices were implemented and in place on. All residents were re-assessed for at risk potential and Care Plans were updated to reflect interventions for preventions. 3. License nurses were re-in serviced by Clinical Support and Medline representative concerning the need for implementation of pressure relieving devices. Nursing assistants were in-serviced -regarding pressure prevention and healing interventions such as turning and repositioning, heels elevated, w/c cushions and heel boots. All residents will receive an admission assessment to ensure areas of skin impairment and risk areas have been identified, measured, appropriate treatment ordered, and prevention interventions executed. Each area of impairment shall have a skin sheet to monitor progress weekly	01/02/2013

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	Admission Assessment & Collection Data form indicated the resident was admitted at 1:00 p.m. The form indicated the resident required assistance of two staff members for transfers, ambulation and toileting. The form indicated the resident's skin was intact and skin plan of care interventions on the form included for the resident to be turned and repositioned, heels to be elevated off surfaces, and pressure relieving devices to be provided. A Skin Impairment Circumstance Investigation form was initiated on 11/12/12. The form indicated wounds were observed on the resident's right heel and left outer ankle. The 11/2012 Treatment Administration Record indicated there were Physician orders obtained on 11/12/12. The Physician orders were to cleanse the area to the left outer heel with wound cleanser, pat dry, apply Santyl to wound bed, and cover the area with a clean dressing every day. There was another Physician's order to apply skin prep (a wipe to dry skin on the area) to the right heel every shift. There was also an order for a Sapphire (a speciality low air loss mattress). Two Pressure/Stasis/Arterial/Diabetic Ulcer Assessment forms were initiated on 11/12/12. The first form indicated a an		and intervene as needed. Individualized care plans will be developed for each resident identified at risk within 24 hours of admission. The DHS or designee will audit each chart within 24 hours of admission to ensure an individualized Care Plan was initiated and interventions are in place. Weekly rounds and review of documentation will be completed by clinical support nurses to monitor skin integrity, identification of wounds, wound healing, treatment and prevention interventions. The License Nurse will be responsible to ensure pressure relieving devices are in place upon admission, when there is skin impairment identified or when resident is determined to be at. DHS or designee will audit 3 resident per day 5 times per week to include all three shifts to ensure the intervention for prevention of skin breakdown is in place. 4. DHS or designee will monitor and report findings to QAA committee for montioring monthly for 6 months or until 100% compliance is obtained. QAA will monitor for any trends and make any modifications to the POC as necessary. 5. Completion date 1/2/13.	

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	Unstageable pressure ulcer was observed on the resident's right heel. The skin was intact and black in color and the area measured 5.0 cm x 6.5 cm with no depth recorded. The following assessments of the wound were recorded as follow: 11/14/12- Unstageable wound, 5.0 cm x 6.5 cm in size, skin intact , black in color 11/22/12- Unstageable wound, 5.0 cm x 6.5 cm in size, skin intact , black in color 11/28/12- Unstageable wound, 5.0 cm x 6.5 cm in size, skin intact , black in color 12/05/12- Unstageable wound, 5.0 cm x 6.5 cm in size, skin intact , black in color 12/12/12- Unstageable wound, 5.0 cm x 6.5 cm in size, skin intact , black in color The second form indicated a Stage III pressure ulcer was identified on the left outer ankle and the wound measured 2 cm x 1 cm and no depth recorded. The wound color was white and Santyl was applied. The following assessments of the wound were recorded as follows: 11/14/12- Stage III, 1.5 cm x 1.5 cm, undetermined depth, no drainage, yellow in color, treatment with Santyl. 11/21/12- Stage III, 1.5 cm x 1.5 cm, undetermined depth, no drainage, 20% red color, 80% yellow in color 11/28/12- Stage III, 1.5 cm x 1.5 cm, undetermined depth, no drainage, 20%			

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	red color, 80% yellow in color 12/05/12- Stage III, 1.5 cm x 1.5 cm, undetermined depth, no drainage, 95% red, 5% yellow in color 12/12/12- Stage III, 1.0 cm x 0.8 cm, undetermined depth, no drainage, 100% red in color When interviewed on 12/13/12 at 11:00 a.m., the Interim Director of Nursing indicated the areas to the resident's right heel and left ankle were first observed on 11/12/12. The Interim Director of Nursing indicated the facility ordered a pressure relieving mattress at that time as the resident had identified risk factors noted prior to 11/12/12. The Interim Director of Nursing indicated the mattress the resident was on prior to 11/12/12 was not a pressure relieving mattress. 2. The closed record for Resident #C was reviewed on 11/13/12 at 9:00 a.m. The resident was admitted to the facility from the hospital on 10/19/12. The resident was discharged to the hospital on 10/29/12. The resident's diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, history of acute kidney injury, spinal stenosis, atherosclerotic disease, diabetic neuropathy, history of anemia, and peripheral artery disease.			

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	The 10/19/12 Nursing Admission Assessment & Data Collection form was reviewed. The form indicated the resident was admitted at 6:40 p.m. via an ambulance. The form also indicated the resident required assistance with grooming, transfers, bathing, dressing, eating, and toileting. The form also indicated the resident had a Stage I or greater wound and the corresponding body diagram indicated a Stage II wound was present on the sacral/coccyx area and 26 staples were noted along the spinal column. The Skin Plan of Care on the form indicated the resident was to have a pressure relieving device to the bed. An Assessment Review and Considerations form was completed on 10/19/12. This form indicated the resident had mobility impairment and medical diagnoses affecting skin oxygenation which were risk factors that contributed to the potential for skin breakdown. Two Pressure/Stasis/Arterial/Diabetic Ulcer Assessment forms were initiated on 11/12/12. The first form indicated a Stage III (an ulcer with full thickness tissue loss without bone, tendon, or muscle exposed) pressure ulcer was present on the resident's coccyx and the color of the wound was yellow. The pressure ulcer measured 3.0 cm x 1.0 cm			

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	with depth of 0.5 cm. The following wound assessments were recorded on the form: 11/14/12- Stage III, 2.5 cm x 1.0 cm, undetermined depth, wound color 100% yellow, no drainage 11/21/12- Stage III, 1.0 cm x 0.8 cm, undetermined depth, wound 60% red and 40% yellow, no drainage. 11/28/12- Stage III, 1.0 cm x 0.6 cm , undetermined depth, wound 80% red, 20% yellow, no drainage 12/5/12- Stage III, 1.0 cm x 0.6 cm, undetermined depth, wound 90% red, 10% yellow, no drainage. The second form indicated a Stage II pressure ulcer was present on the resident's right inner buttock. The wound measured 1.5 cm x 1.0 cm and was red in color. The following wound assessments were recorded on the form: 11/14/12- Stage II, 2.5 cm x 1.0 cm, wound 100% red, no drainage present. 11/21/12- Stage II, 0.5 cm x 0.3 cm, wound 100% red, no drainage present. 11/28/12- Area resolved. When interviewed on 12/13/12 at 11:00 a.m., the Interim Director of Nursing indicated residents were to have a low air loss or pressure relieving mattress if they had multiple Stage II pressure ulcers, Stage III or higher ulcer, high risk factors,			

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	or were on bedrest. This federal tag relates to Complaint IN00120199. 3.1-35(g)(2)			

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F0314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure pressure relieving devices were in place for residents identified with pressure ulcers or at risk for the development of pressure ulcers for 2 of 4 residents reviewed for pressure ulcers in the sample of 8. This resulted in the development of an unstageable pressure ulcer and a Stage III pressure ulcer. (Residents #B and #C). The facility also failed to ensure individual treatments were in place for residents with multiple pressure ulcers for 2 of 4 residents reviewed for pressure ulcers in the sample of 8. (Residents #C and #E) Finding include: 1. On 12/13/13 at 8:55 a.m., Resident #B was observed sitting in a wheel chair the unit Dining Room. The resident had blue Multipodus boots on both of her feet.	F0314	F314 1. Resident B was place on a pressure relieving mattress on 11/12/12. Resident C was discharged on 10/29/12. Resident E was discharged on 12/15/122. All residents Care plans were updated on 12/28/12 for resident with specific approaches related pressure relieving devices were implemented and in place on. All residents were re-assessed for at risk potential and Care Plans were updated to reflect interventions for preventions. 3. License nurses were re-in serviced by Clinical Support and Medline representative concerning the need for implementation of pressure relieving devices. Nursing assistants were in-serviced regarding pressure prevention and healing interventions such as turning and repositioning, heels elevated, w/c cushions and heel boots. All residents will receive an admission assessment	01/02/2013

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	The record for Resident #B was reviewed on 12/12/12 at 2:00 p.m. The resident's diagnoses included, but were not limited to, sickle cell anemia, brain tumor, arthritis, congestive heart failure, deep vein thrombosis, diabetes mellitus, and multiple myeloma. The resident was originally admitted to the facility in 2010 and was last readmitted on 10/18/12. Review of the 10/18/12 Nursing Admission Assessment & Collection Data form indicated the resident was admitted at 1:00 p.m. The form indicated the resident required assistance of two staff members for transfers, ambulation and toileting. The form indicated the resident's skin was intact and skin plan of care interventions on the form included for the resident to be turned and repositioned, heels to be elevated off surfaces, and pressure relieving devices to be provided. A Skin Impairment Circumstance Investigation form was initiated on 11/12/12. The form indicated wounds were observed on the resident's right heel and left outer ankle. The 11/2012 Treatment Administration Record indicated there were Physician orders obtained on 11/12/12. The Physician orders were to cleanse the area to the left		to ensure areas of skin impairment and risk areas have been identified, measured, appropriate treatment ordered, and prevention interventions executed. Each area of impairment shall have a skin sheet to monitor progress weekly and intervene as needed. Individualized care plans will be developed for each resident identified at risk within 24 hours of admission. The DHS or designee will audit each chart within 24 hours of admission to ensure an individualized Care Plan was initiated and interventions are in place. Weekly rounds and review of documentation will be completed by clinical support nurses to monitor skin integrity, identification of wounds, wound healing, treatment and prevention interventions. The License Nurse will be responsible to ensure pressure relieving devices are in place upon admission, when there is skin impairment identified or when resident is determined to be at risk. DHS or designee will audit 3 resident per day 5 times per week to include all three shifts to ensure the intervention for prevention of skin breakdown is in place. 4. DHS or designee will monitor and report findings to QAA committee for montioring monthly for 6 months or until 100% compliance is obtained. QAA will monitor for any trends and make modifications to the POC as necessary. 5.	

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	outer heel with wound cleanser, pat dry, apply Santyl to wound bed, and cover the area with a clean dressing every day. There was another Physician's order to apply skin prep (a wipe to dry skin on the area) to the right heel every shift. There was also an order for a Sapphire (a speciality low air loss mattress). Two Pressure/Stasis/Arterial/Diabetic Ulcer Assessment forms were initiated on 11/12/12. The first form indicated a an Unstageable pressure ulcer was observed on the resident's right heel. The skin was intact and black in color and the area measured 5.0 cm x 6.5 cm with no depth recorded. The following assessments of the wound were recorded as follow: 11/14/12- Unstageable wound, 5.0 cm x 6.5 cm in size, skin intact , black in color 11/22/12- Unstageable wound, 5.0 cm x 6.5 cm in size, skin intact , black in color 11/28/12- Unstageable wound, 5.0 cm x 6.5 cm in size, skin intact , black in color 12/05/12- Unstageable wound, 5.0 cm x 6.5 cm in size, skin intact , black in color 12/12/12- Unstageable wound, 5.0 cm x 6.5 cm in size, skin intact , black in color The second form indicated a Stage III pressure ulcer was identified on the left outer ankle and the wound measured 2 cm x 1 cm and no depth recorded. The		Completion date 1/2/13.	

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	wound color was white and Santyl was applied. The following assessments of the wound were recorded as follows: 11/14/12- Stage III, 1.5 cm x 1.5 cm, undetermined depth, no drainage, yellow in color, treatment with Santyl. 11/21/12- Stage III, 1.5 cm x 1.5 cm, undetermined depth, no drainage, 20% red color, 80% yellow in color 11/28/12- Stage III, 1.5 cm x 1.5 cm, undetermined depth, no drainage, 20% red color, 80% yellow in color 12/05/12- Stage III, 1.5 cm x 1.5 cm, undetermined depth, no drainage, 95% red, 5% yellow in color 12/12/12- Stage III, 1.0 cm x 0.8 cm, undetermined depth, no drainage, 100% red in color When interviewed on 12/13/12 at 11:00 a.m., the Interim Director of Nursing indicated the areas to the resident's right heel and left ankle were first observed on 11/12/12. The Interim Director of Nursing indicated the facility ordered a pressure relieving mattress at that time as the resident had identified risk factors noted prior to 11/12/12. The Interim Director of Nursing indicated the mattress the resident was on prior to 11/12/12 was not a pressure relieving mattress. 2. On 12/13/12 at 10:45 a.m., LPN #1			

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	was observed completing a wound care treatment for Resident #E. The LPN removed a dressing from the residents coccyx. A scant amount of bloody drainage was observed on the dressing. A pressure ulcer was observed to the resident's coccyx. The open area measured approximately 1 cm (centimeter) x .5 cm with a red center. No odor was noted. There were no other open areas on the resident's coccyx or buttock areas. The record for Resident #E was reviewed on 12/12/12 at 1:30 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, left hip fracture, coronary artery disease, chronic kidney disease, congestive heart failure, open toe wound, and venous insufficiency. The resident was admitted to facility from the hospital on 11/6/12. Review of the 10/24/12 hospital Rehabilitation records indicated the resident had a decubitus (pressure ulcer) to the sacral area and was receiving wound care. Review of the 11/6/12 admission Physician orders indicated there were orders to apply Santyl (an ointment to debride ulcers) to the right great toe two times a day and also apply Silvadene (an			

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	ointment to treat wounds) cream to the right great toe two times a day. There were no Physician orders for any treatment to the coccyx or buttock areas. A Physician order was written on 11/12/12 to cleanse the area on the resident's coccyx with wound cleanser, pat dry, and apply Santyl to the wound bed and cover the area every other day. Review of the 11/6/12 (no time documented) Nursing Admission Assessment & Data Collection form indicated the resident had a left hip fracture and required assistance with transfers, ambulation, bathing, toileting, and dressing. The form also indicated the resident did not have a Stage I wound or greater present and the resident was not at risk for developing pressure ulcers. There was a body diagram on the Nursing Admission Assessment & Data Collection form to note any skin impairments observed. The only areas marked on diagram were a bruise to the resident's head and sutures to the left hip area. The Skin Plan of Care on the form did not indicate a pressure relieving device was to be in place to the resident's bed. An Assessment Review and Considerations form completed on 11/6/12 indicated staff were to mark if the resident had risk factors of mobility impairment, past			

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	155764	A. BUILDING 00 B. WING	12/14/2012

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	history, or medical diagnoses affecting skin oxygenation. None of the above areas were checked as being applicable to the resident. A Skin Impairment Circumstance, Assessment and Intervention form was initiated on 11/12/12 (no time listed). The form indicated the resident had two Stage II (an ulcer with partial thickness loss of the skin dermis with a red or pink ulcer bed) pressure ulcers. The pressure areas were located on the resident's left inner buttock and the coccyx areas. Two Pressure/Stasis/Arterial/Diabetic Ulcer Assessment forms were initiated on 11/12/12. The first form indicated a Stage III (an ulcer with full thickness tissue loss without bone, tendon, or muscle exposed) pressure ulcer was present on the resident's coccyx and the color of the wound was yellow. The pressure ulcer measured 3.0 cm x 1.0 cm with depth of 0.5 cm. The following wound assessments were recorded on the form: 11/14/12- Stage III, 2.5 cm x 1.0 cm, undetermined depth, wound color 100% yellow, no drainage 11/21/12- Stage III, 1.0 cm x 0.8 cm, undetermined depth, wound 60% red and 40% yellow, no drainage. 11/28/12- Stage III, 1.0 cm x 0.6 cm ,			

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	undetermined depth, wound 80% red, 20% yellow, no drainage 12/5/12- Stage III, 1.0 cm x 0.6 cm, undetermined depth, wound 90% red, 10% yellow, no drainage. The second form indicated a Stage II pressure ulcer was present on the resident's right inner buttock. The wound measured 1.5 cm x 1.0 cm and was red in color. The following wound assessments were recorded on the form: 11/14/12- Stage II, 2.5 cm x 1.0 cm, wound 100% red, no drainage present. 11/21/12- Stage II, 0.5 cm x 0.3 cm, wound 100% red, no drainage present. 11/28/12- Area resolved. Review of the 11/13/12 Nutrition Assessment and Data Collection form indicated the Registered Dietitian noted resident stated he had a wound to the coccyx for eight months. The form also indicated the resident currently had open areas to the coccyx, left upper buttock, and right great toe. The Registered Dietitian's recommendations included to monitor the resident's oral intake and add 4 ounces of 2.0 Nutritional Supplement three times a day for skin healing. When interviewed on 12/13/12 at 11:00 a.m., the Interim Director of Nursing indicated the resident's open area to the			

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	coccyx was present and not identified when admitted. The Interim Director of Nursing indicated the coccyx wound was first observed on 11/121/2 when the facility performed skin checks for the residents. The Interim Director of Nursing indicated the pressure ulcer was a Stage III when it was first observed and treatment orders and a specialty low air loss mattress were ordered at that time The Interim Director of Nursing indicated residents were to have a low air loss or pressure relieving mattress if they had multiple Stage II pressure ulcers, Stage III or higher ulcer, high risk factors, or were on bedrest. The Interim Director of Nursing indicated the resident had been receiving Home Health care before his hospitalization and had the wound then. The Interim Director of Nursing indicated the resident should have received treatment for the wound upon admission. The Interim Director of Nursing indicated the resident had risk factors such as mobility impairment and medical diagnoses affecting skin oxygenation upon admission and this should have been noted on the initial assessment form. The Interim Director of Nursing indicated the pressure relieving devices should have been initiated upon admission for a Stage III pressure ulcer. 3. The closed record for Resident #C was			

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	reviewed on 11/13/12 at 9:00 a.m. The resident was admitted to the facility from the hospital on 10/19/12. The resident was discharged to the hospital on 10/29/12. The resident's diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, history of acute kidney injury, spinal stenosis, atherosclerotic disease, diabetic neuropathy, history of anemia, and peripheral artery disease. The 10/19/12 Nursing Admission Assessment & Data Collection form was reviewed. The form indicated the resident was admitted at 6:40 p.m. via an ambulance. The form also indicated the resident required assistance with grooming, transfers, bathing, dressing, eating, and toileting. The form also indicated the resident had a Stage I or greater wound and the corresponding body diagram indicated a Stage II wound was present on the sacral/coccyx area and 26 staples were noted along the spinal column. The Skin Plan of Care on the form indicated the resident was to have a pressure relieving device to the bed. An Assessment Review and Considerations form was completed on 10/19/12. This form indicated the resident had mobility impairment and medical diagnoses affecting skin oxygenation which were risk factors that contributed to the			

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	potential for skin breakdown. There were two Pressure/Stasis/Diabetic Ulcer Assessment forms completed for the resident. The first form indicated an Unstageable pressure ulcer was first observed on the resident's coccyx upon admission to the facility on 10/19/12. The pressure ulcer measured 5.5 cm x 1 cm with depth of 0.2 cm, the wound bed was red/yellow in color, no drainage was noted, and the treatment being used was Santyl ointment. The following wound assessment was recorded: 10/24/12 -Unstageable, measuring 7.6 cm x 6 cm with undetermined depth, moderate amount of bloody drainage, wound bed with 50% red, 50% slough, no odor noted, and the treatment was Santyl. The section on the form titled "current preventative interventions" was blank. There were no further assessments of the wound recorded on the form. The second form indicated a Stage II pressure ulcer was first observed on the resident's right inner gluteus upon admission to the facility on 10/19/12. There were no measurements recorded, the color of the wound was red, no odor was noted, and the treatment being used was Santyl.			

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	The following wound assessment was recorded: 10/24/12- Stage II, measuring 2 cm x 1.2 cm with less then 0.1 cm depth, the wound was 100% red and no drainage or odor noted, and the treatment being used was Santyl. The section on the form titled "current preventative interventions" was blank. There were no further assessments of the wound recorded on the form. Review of the 10/19/12 admitting Physician orders indicated there was an order to cleanse the wound to the coccyx with wound wash, pat dry, and apply Santyl with an optifoam(a type of dressing). There were no Physician orders for wound care to the right inner gluteus area. Review of the 10/2012 Treatment Record indicated the above ordered treatment was signed out as being completed. There was no documentation of any treatment being performed on the right inner gluteus wound. When interviewed on 12/13/12 at 11:00 a.m., the Interim Director of Nursing indicated residents were to have a low air loss or pressure relieving mattress if they had multiple Stage II pressure ulcers, Stage III or higher ulcer, high risk factors,			

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	or were on bedrest. When interviewed on 12/13/12 at 1:45 p.m., the Interim Director of Nursing indicated the resident had two pressure ulcer as per the wound assessment sheets and there should have been a separate order for each wound as they were different stages. The Interim Director of Nursing also indicated the pressure ulcer to the right gluteal area should have been measured upon admission. The Interim Director of Nursing indicated the wound sheets noted treatment being done to the areas was Santyl. The Interim Director of Nursing indicated she had a listing of resident's with pressure relieving specialty or low air loss mattress and it did not appear the resident had a pressure relieving mattress which she should have had in place due to her wounds and risk factors. This federal tag relates to Complaint IN00120199. 3.1-40(a)(2)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview the facility failed to ensure clinical records were complete related to the documentation of Physician and family notification of changes in pressure ulcer assessments for 1 of 4 residents reviewed with pressure ulcers in the sample of 8. (Resident #C) Findings include: The closed record for Resident #C was reviewed on 11/13/12 at 9:00 a.m. The resident was admitted to the facility from the hospital on 10/19/12. The resident was discharged to the hospital on 10/29/12. The resident's diagnoses included, but were not limited to, diabetes mellitus, high blood pressure, history of acute kidney injury, spinal stenosis,	F0514	F514 1. Resident C was discharged on 10/29/12. 2. All residents with presure ulcers were assessed on 12/28/12 to ensure Physician and family notification of changes in pressue ulcer assessment. Any deficiencies noted were corrected at this time. 3. License nurses were re-inserviced on 12/28/12 on notification of Physician and families of changes in pressure ulcer assessments. . All residents will receive an admission assessment to ensure areas of skin impairment and risk areas have been identified, measured, appropriate treatment ordered, and prevention interventions executed. Weekly rounds and review of documentation will be completed by clinical support nurses to	01/02/2013

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	atherosclerotic disease, diabetic neuropathy, history of anemia, and peripheral artery disease. The 10/19/12 Nursing Admission Assessment & Data Collection form was reviewed. the form indicated the resident was admitted at 6:40 p.m. via an ambulance. The form also indicated the resident required assistance with grooming, transfers, bathing, dressing, eating, and toileting. The form also indicated the resident had a Stage I or greater wound and the corresponding body diagram indicated a Stage II wound was present on the sacral/coccyx area and 26 staples were noted along the spinal column. There were two Pressure/Stasis/Diabetic Ulcer Assessment forms completed for the resident. The first form indicated an Unstageable pressure ulcer was first observed on the resident's coccyx upon admission to the facility on 10/19/12. The pressure ulcer measured 5.5 cm x 1 cm with depth of 0.2 cm, the wound bed was red/yellow in color, no drainage was noted, and the treatment being used was Santyl ointment. The following wound assessment was recorded: 10/24/12 -Unstageable, measuring 7.6 cm x 6 cm with undetermined depth,		monitor skin integrity, identification of wounds, wound healing, treatment and prevention interventions. DHS or designee will audit all resident with wound documention weekly to ensure notification to Physican and families of any change of in assessment. 4. DHS or designee will monitor and report findings to QAA committee for montioring monthly for 6 months or until 100% compliance is obtained. QAA will monitor for any trends and make any modifications to the POC as necessary. 5. Completion date 1/2/13.	

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	moderate amount of bloody drainage, wound bed with 50% red, 50% slough, no odor noted, and the treatment was Santyl. The section on the form titled "current preventative interventions" was blank. There were no further assessments of the wound recorded on the form. The second form indicated a Stage II pressure ulcer was first observed on the resident's right inner gluteus upon admission to the facility on 10/19/12. There were no measurements recorded, the color of the wound was red, no odor was noted, and the treatment being used was Santyl. The following wound assessment was recorded: 10/24/12- Stage II, measuring 2 cm x 1.2 cm with less then 0.1 cm depth, the wound was 100% red and no drainage or odor noted, and the treatment being used was Santyl. The section on the form titled "current preventative interventions" was blank. There were no further assessments of the wound recorded on the form. Review of the Nurses' Notes and Circumstance follow up documentation indicated there was no documentation of the resident's Physician or family being notified of the change in the assessment			

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	of the resident's coccyx wound on 10/24/12. When interviewed on 12/13/12 at 1:50 p.m., LPN #2 indicated she measured and assessed the resident's pressure ulcers on 10/24/12. The LPN indicated she informed the Physician of the change and no orders were given. The LPN indicated she also informed the resident's family. LPN #2 indicated she did not document the notification of the family and Physician in the resident's clinical record. This federal tag relates to Complaint IN00120199. 3.1-50(a)(1) 3.1-50(a)(2)			